Hip and Knee Questionnaire

Name: ____ **Date:** __________________

Area of problem: ◯ Right Hip ◯ Left Hip

◯ Right Knee ◯ Left Knee

Type of problem: ◯ Pain ◯ Swelling ◯ Stiffness

◯ Locking ◯ Catching ◯ Other ____________________

Quality: ◯ sharp ◯ dull ◯ aching ◯ burning ◯ other____________

Timing: ◯ constant ◯ intermittent ◯ daily ◯ occasional

Please rate your pain during the following activities from 1-5 (5 being the worst)

	None	Very Mild	Mild	Moderate	Severe
Walking	1	2	3	4	5
Going up or down stairs	1	2	3	4	5
Getting up from a chair	1	2	3	4	5
Lying in bed at night	1	2	3	4	5
Getting up from kneeling	1	2	3	4	5

What makes it worse? ____

What makes it better? ____

What treatments have you tried?

◯ none ◯ rest ◯ ice ◯ heat ◯ physical therapy

◯ brace ◯ injections ◯ cane ◯ acupuncture

◯ medication ______________________ ◯ surgery: ____________________